Outpatient Surgery, Hospital Based

Overview

A hospital-based outpatient surgery center (PT 10) operates exclusively for the purpose of providing outpatient surgical services that do not require inpatient hospitalization and the duration of services is not expected to exceed 24 hours following an admission. A hospital-based outpatient surgery center can administer anesthesia (e.g., general, moderate sedation, regional), monitor the patient, provide postoperative care, and resuscitate, as necessary.

Covered services

Medicaid reimburses covered, medically necessary surgical procedures that have been assigned an Ambulatory Surgery Center (ASC) level by Medicaid (reference the Rates, Outpatient Surgery, ASC Groups and Procedures document on the Division of Health Care Financing and Policy (DHCFP) website: http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/), appropriately furnished in a hospital-based outpatient surgery center and authorized by the QIO-like vendor (Gainwell Technologies, also referred to as Nevada Medicaid), when applicable.

Sterilization

When a sterilization procedure is performed, a Sterilization Consent Form must be submitted electronically with the claim or be on file with the DHCFP QIO-like vendor. Failure to provide this form will result in claim denial when a copy of the form is not on file with the QIO-like vendor at the time the facility submits their claim. For additional requirements, see the Sterilization and Abortion Policy document at the Provider Billing Information website at: https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_Sterilization.pdf.

Wound Care Management

For further information on medically necessary wound care applications and skin substitutes, please refer to Medicaid Services Manual (MSM) Chapter 600, Physician Services, Attachment A, Policy #6-02 and to the DHCFP Fee For Service (FFS) Fee Schedule.

The following skin substitutes are billable and require prior authorization: Q4133, Q4186, Q4101. Either the signed and dated treatment plan or the letter of medical necessity must be uploaded with the Outpatient Medical/Surgical Services Prior Authorization Request (Form FA-6).

The following application codes are billable without a prior authorization: 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278.

Non-covered services

Medicaid does not cover services in an outpatient surgery, hospital based center that are not medically necessary, are not assigned an ASC level by Medicaid (reference the Rates, Outpatient Surgery, ASC Groups and Procedures document on the DHCFP website: http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/), are authorized to be performed at an Inpatient level of service, or are specified in the MSM as a non-covered benefit (e.g., experimental surgeries, fertility restoration). Cosmetic surgery is not a Medicaid covered benefit, except for the immediate repair of an accidental injury or the improvement of a malformed body member which coincidentally services some cosmetic purpose. Refer to MSM Chapter 200 Section 207 and Chapter 600 Section 603.10F.

If the service has been authorized as an inpatient service, the service will not be paid as an outpatient surgery.

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Authorizations

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Services that require authorization

- To determine if authorization is required refer to the Medicaid Services Manual that is specific to the service being provided, and the Fee Schedules. Providers may also access the authorization criteria function on the Provider Web Portal at https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx as requiring authorization. (Select "Authorization Criteria" under "Resources." You do not need to log in.) A prior authorization requirement applies to procedures performed in-state or out-of-state. Providers must also check the ASC Payment Groups and Procedures list to be sure that an ASC level is assigned to the code for reimbursement by Medicaid.
- The following require a prior authorization: Services that are normally performed in a physician's office, emergency room, urgent care, diagnostic center or clinic.
- Any procedure requiring prior authorization when performed in conjunction with a procedure exempt from authorization.

Prior authorization is not required for a Medicare Part B/Medicaid dual eligible recipient when Medicare benefits are not exhausted. Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Requesting authorization

To request authorization, complete form FA-6 and use the online prior authorization system to complete/submit required information online.

Managed Care Organization versus Fee For Service

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO.

When a recipient is enrolled in the FFS plan, request prior authorization from and submit claims to the QIO-like vendor.

Rates

Reference the ASC Payment Groups and Procedures list, specifying ASC levels assigned to specific CPT codes, located at: http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/ (select "Rates," then accept the license agreement, then select "ASC Groups and Procedures" under "Outpatient Surgery"). Surgical procedure codes without an assigned ASC level are not reimbursed by Medicaid when the surgery is performed in a hospital-based outpatient surgery center.

Reimbursement is an all-inclusive rate based on the ASC Level assigned to the surgical procedure.

Billing for BAHA, Cochlear, Baclofen Pump, Vagus Nerve Stimulator Implants

Medicaid reimburses these four implants using an all-inclusive rate that includes the Healthcare Common Procedure Coding System (HCPCS) device and all associated services for the ASC payment group.

A prior authorization must be obtained from the QIO-like vendor for the appropriate CPT surgical code.

For additional information regarding Cochlear, Baha, VNS, and Baclofen Pump implant policy, reference MSM Chapter 2000, Audiology Services, and Chapter 600, Section 603.10 Physician Services, In Outpatient Setting.

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The physician/surgeon (PT 20) must obtain a separate prior authorization for the surgical procedure performed. Reference MSM Chapter 600.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature:

https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx.